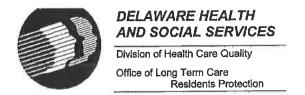
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		-	A. DOILD			С		
		085021	B. WING			07/2	23/2019	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MILLCRO) FT	8			55 POSSUM PARK ROAD			
WILLOW	51 1			N	IEWARK, DE 19711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		FC	000				
	conducted at this fa through July 23, 20 resident's clinical re facility documentati	complaint survey was acility from July 18, 2019 19. Interviews, review of ecords and review of other on were conducted. The irst day of the survey was 73. size was 3.						
	No deficiencies wer	re identified during the survey.						
ABOBATORY	DIDECTOR'S OR BROWN	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIDE		TITLE		(X6) DATE	
	ically Signed	ELVOOL LEIEK NEI MEGENTATIVE O OLO	OIL		111		07/26/2019	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



3 Mill Road, Sulte 308 Wilmington, Delaware 19806 (302) 421-7400

STATE SURVEY REPORT

Page 1 of 1

NAME OF FACILITY: Millcroft

DATE SURVEY COMPLETED: July 23, 2019

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	DATE
3201 3201.1.0 3201.1.2	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from July 18, 2019 through July 23, 2019. Interviews, review of resident's clinical records and review of other facility documentation were conducted. The facility census the first day of the survey was 73. The survey sample size was 3. Regulations for Skilled and Intermediate Care Facilities Scope Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. No deficiencies were identified during the survey.	CORRECTION OF DEFICIENCIES	

signature John AVS

Title _ Executive Director Date _ 7/25/19

Provider's Signature_